Health Insurance Coverage

Definition: A mechanism to provide financial access to needed health care services and distribute the costs and risks. Financial barriers to receiving health care also include inadequate scope of benefits and inability to afford co-payments, deductibles, and other uncovered costs.

Summary

An estimated 625,000 Washington residents (12.2% ±1.2 of the population) were without health insurance coverage in 1994, as reported by the state Office of Financial Management using findings from a national Robert Wood Johnson Foundation Survey.[1] For the U.S. in 1994 the estimate was 15.2%.[2] An estimate of the uninsured Washington state population for 1996 done by the Health Care Policy Board is 12%.

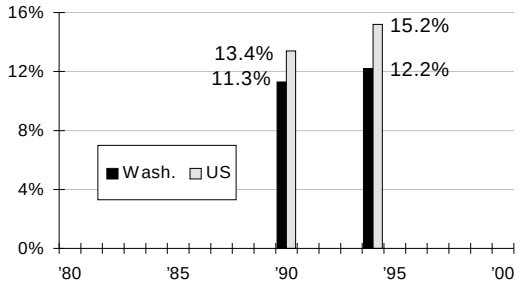
Studies show that adults and children with no insurance were sicker, had fewer ambulatory care visits, and had less continuity of care than insured people. Studies also have found that uninsured people are more likely to undergo avoidable hospitalization or institutionalization, be diagnosed at later stages of life-threatening diseases, be hospitalized on an emergency or urgent basis, be more seriously ill upon hospitalization, and die in the hospital.[3]

Time Trends

Three different studies (1990, 1994, 1996) found that the percent of Washington State uninsured is around 12%. The Health Care Policy Board is contracting to have the Robert Wood Johnson Family Study redone in the fall of 1996.

The total number and the percent of people uninsured in the US increased between 1990 and 1994.[4, 5]

Percent of Population Without Health Insurance, 1990 and 1994



The national 1994 Robert Wood Johnson (RWJ) Foundation survey also found that employer-based coverage declined from 1990 to 1994 and that Medicaid expansions only partially offset the employment coverage decline.[6] In Washington, employer-based coverage has declined significantly, from over 80% of employers providing health insurance in 1980 to only 64% in 1993[7]. The Health Care Policy Board projected the following Washington state health insurance sponsorship for 1996:

Employer	52%
Medicare	12%
Medicaid	11%
Dept. of Defense	6%
Basic Health Plan (adults)	1%
Uninsured	12%

These projections continue to suggest that employer based coverage is declining

The RWJ study used three scenarios to project the percentage of uninsured Americans in the year 2000. In all three, the figure increased to 25%.

Year 2000 Goal

There is no official year 2000 goal for health insurance coverage in Washington. The 1993 Health Services Act had the goal of universal access. Since its repeal, Washington state's primary mechanism for increased financial access is the Basic Health Plan (1995 ESHB 1046) which is available to Washington state residents who are not eligible for Medicare. It offers a standard set of comprehensive health benefits through private health plans in Washington State. (See p. 9.6 for more detail on the Basic Health Plan).

Geographic Variation

A study done by Arthur Anderson and Company in 1994[8] showed that the statewide uninsured percentage was 12%. The 28 counties designated as rural had an uninsured rate of 16.2% and the urban counties had an uninsured rate of 11.1%. The rural counties designated as frontier and remote showed uninsured percentages of

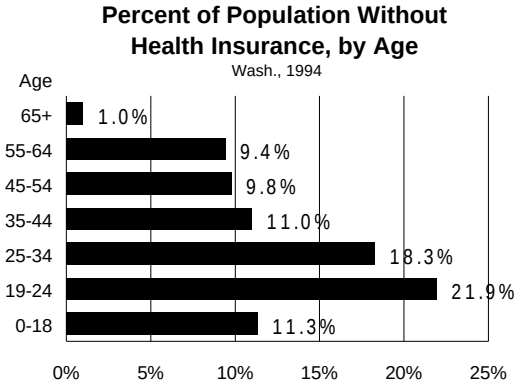
17.6% and 20.2%, with less remote counties at 15.1% uninsured.

Gender

Of those without health insurance in Washington in 1994, an estimated 52% were male and 48% female.

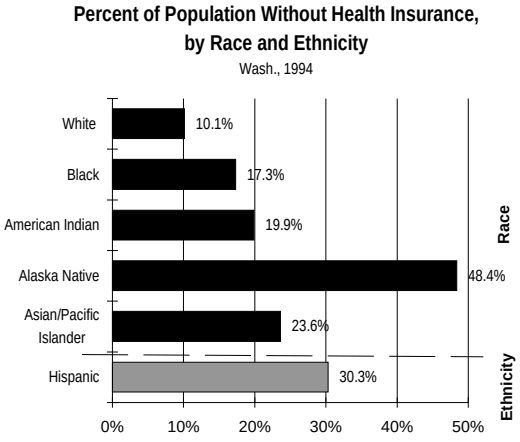
Age

In Washington state in 1994, the age groups with the highest percentages of uninsured were young adults age 19-24 and 25-34.



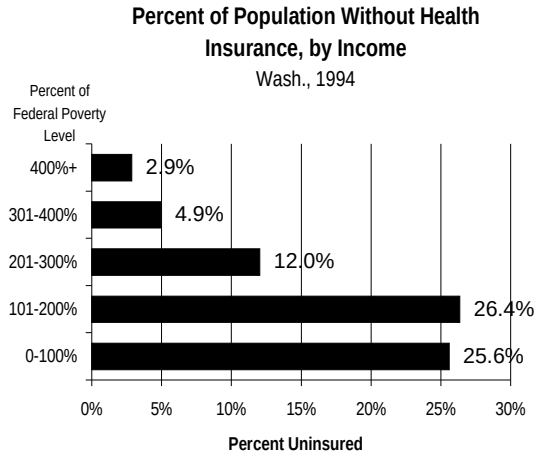
Race and Ethnicity

In 1994, according to the RWJ study, all racial and ethnic minority groups in Washington had higher percentages of uninsured than whites.



Income and Education

The percentage of people without health coverage in Washington in 1994 was significantly higher in lower income groups. Over 25% of people with income below the federal poverty level were uninsured. An even higher percentage of those with income between one and two times poverty level were uninsured; this is because many of these people, while poor, are not poor enough to qualify for Medicaid or are otherwise ineligible.



Sponsors and Payers of Coverage

The following are the primary sponsors or payers of health coverage and the percent of Washington's population whose coverage is financed by those sources:[9]

Employer	63.6%
Medicare	9.3%
Medicaid	7.8%
Privately Insured	6.4%
Employer & Medicaid	0.7%
Uninsured	12.2%
	100.0%

Note: The Health Care Authority indicates that in December, 1994, there were 50,476 people in the Basic Health Program. They are included in the above sources.

Other Measures of Impact and Burden

Access to care and health outcomes. A number of studies[10] have found that adverse outcomes appear related to the lack of health insurance coverage. Even after statistically adjusting for the patients' health status upon hospital admission, these studies show that uninsured patients are more likely than insured patients to experience avoidable hospitalization or institutionalization, be diagnosed at later stages of life-threatening diseases, be hospitalized on an

emergency or urgent basis, be more seriously ill upon hospitalization, and die in the hospital.

A national Office of Technology Assessment background paper[11] reviews the scientific literature linking health insurance status with access to and use of health services, and with individual health outcomes. Another study by the Agency for Health Care Policy and Research[12] examines the effect of insurance coverage on access to health care. Some summary conclusions:

- Uninsured patients may receive negligent care more often than those with health insurance.
- Publicly insured people are more likely to receive less intensive or lower quality care than those who are privately insured.
- People without insurance must travel farther and wait longer to see providers.
- Patient health can be adversely affected by a lack of insurance even after patients have gained access to care. This occurs when people have not had benefits of preventative services and develop disease with lasting impact (for example, uncontrolled hypertension which leads to kidney disease) or are diagnosed in later stages of disease (for example breast cancer which metastasizes).

Adequacy of coverage. Data exist on percent of people with coverage, but not on the level of coverage.

Risk and Protective Factors

The following are major factors that influence the ability of people in Washington to have and maintain health coverage:

Medicare. In Washington state in 1994, 95.8% of people 65 years or older had Medicare insurance.[13] There is discussion and concern about proposals to reduce federal spending growth. Medicare recipients on fixed incomes are concerned they will be unable to afford increased co-payments, or will be affected by cutbacks in benefit levels.

Medicaid. Proposed changes in federal Medicaid funding could result in reduced Federal funding to the state. Depending on the extent of these reductions, the state will have to make decisions on where to put available funding. Currently, the state's Healthy Options Program covers over 380,000 clients and will include approximately 3,085 providers in 1996.[14] It is a cost-effective model of health care reimbursement.

Washington's Basic Health Plan. The total enrollment in December, 1995 was 84,000. The target enrollment for June 1996 is 100,000, and for June 1997 it is 200,000. [15]

Managed care. Health care in Washington is increasingly moving toward managed care, which is defined as "an integrated system of insurance, financing, and health service delivery which focuses on the appropriate and cost-effective use of health services delivered through defined networks of providers and proper allocation of financial risk."[16]

In 1994, nearly 85% of the people in Washington with health coverage received their care from a health maintenance or preferred-provider organization.[17] While managed care seems to provide incentives to keep people healthy at reasonable cost, it is not yet clear whether this is happening.

Data are not currently available to determine what proportion of Washington's managed care population have benefits at least equivalent to those in the Basic Health Plan, nor do coordinated data systems exist to assess the health outcomes of managed care populations over the long term.

Insurance Reforms and Markets. Various insurance reforms initiated in 1993 and amended in 1995 are being implemented:

- Prohibiting pre-existing condition exclusions of longer than three months.
- Limiting waiting periods to a maximum of three months.
- Requiring carriers to issue insurance products to any applicant regardless of health status ("guaranteed issue").
- Modified community rating, which defines age bands and limits the range between the highest and lowest premiums carriers can charge.
- The elimination of health underwriting, which means that insurers cannot use health status as a factor in setting premiums.

Several carriers have applied to the Insurance Commissioner for substantial premium increases for their individual plans. A preliminary data analysis by the Health Care Policy Board suggests that, while there was a moderate increase in claims per enrollee, many enrollees may have switched carriers to find better rates or switched to lower

priced products with the same carrier, bringing down the average premiums per enrollee. This reduction in average premiums earned, together with a moderate increase in medical claims, has resulted, in some cases, in outlays greater than revenues. If premiums rise, some individuals may drop coverage or switch to the Basic Health Plan. The number of people uninsured may increase if individual product premiums rise to prohibitive levels, and there may be a shift from privately to publicly sponsored coverage.[18]

Rural and "fragile" communities. There are special problems obtaining and maintaining insurance contracts in rural areas where employers are fewer and smaller, populations are smaller and more spread out, and providers are fewer. Current federal reimbursement for Medicare and Medicaid is generally lower for rural hospitals and providers than for their urban counterparts. Since a higher proportion of funding for rural health care comes from public sources, an early effect of federal funding changes is likely to be in rural areas.[19]

Intervention Points, Strategies and Effectiveness

Washington state has a mixed public-private system of financing health care. It has been referred to as a "patchwork."[20]

Attempts to systematically explore the breadth and depth of the problem require an understanding of the many factors affecting personal health, the complicated nature of the health care delivery system, and how components of the system respond to numerous diverse financial incentives.

Medicare. As the population ages, Medicare will be an increasingly significant part of the financing system, with a potential greater role for the state in what have primarily been federal issues regarding scope of coverage, service delivery and reimbursement methods, and coverage for low-income people who are unable to afford premiums and/or necessary co-pays..

Managed Care. While much remains to be learned about the effects of managed care on long-term health outcomes, it is the mechanism most likely to be used to manage the cost and quality of health care.

Medicaid. Federal changes are underway which will affect the scope and delivery of Medicaid services. The state needs to be prepared to respond to potential changes in federal funding and requirements. The Medical Assistance Administration, the Legislature, providers, clients and their advocates, and other partners can continue to work closely together to ensure that the gains of the Healthy Options program are maintained and improved.

Basic Health Plan. This plan, administered by the Washington State Health Care Authority, is available to Washington state residents who are not eligible for Medicare. It offers a standard set of comprehensive health benefits through private health plans in Washington State. The benefits include provider visits, hospital care, prescription drugs, preventive care and limited mental health and chemical dependency treatment. Additional benefits are available to children enrolled in Basic Health Plus, a program coordinated with Medicaid for children eligible for a reduced premium. Maternity services are covered either through Basic Health or by coordinating coverage with Medical Assistance. Premiums vary according to income. If a member's family income is below the Basic Health income guidelines the member will get a discount on the premium. Members with the lowest income pay only $10 per member per month or $20 per family. There are various options whereby employers and others can sponsor coverage for qualifying members.

At current rates of growth, BHP expects to enroll approximately 130,000 subsidized individuals by the fall of 1996 and to have available funding to sustain that enrollment through the end of this biennium.

Insurance Markets. Monitoring systems are needed to assess the effects of insurance reforms which have increased access to financial coverage, such as guaranteed issue and limited waiting period for pre-existing conditions. Data are also needed to compare levels of health insurance benefits with those of the Basic Health Plan.

With increasing integration among provider networks, health plans, and insurance companies, policy decisions regarding licensure, regulation, and reserve requirements take on added importance because of their potential effects on care delivery and effectiveness.

For More Information

Department of Health, Office of Community and Rural Health, 360-705-6770.

Endnotes:

[1] Wei Yen, OFM, Forecasting Division, selected statistics from the RAND RWJF 1994 Family Survey, December, 1995.

[2] Joel Cantor, Steve Long, Susan Marquis, "Recent Results from the RWJF Family Health Insurance Survey", November 1995.

[3] "Does Health Insurance Make a Difference?" Background Paper, Congress of the United States Office of Technology Assessment, September, 1992.

[4] Joel Cantor, Steve Long, Susan Marquis, "Recent Results from the RWJF Family Health Insurance Survey," November 1995.

[5] 1990 Washington Health Care Estimates, A Resource Publication for Policy Analysis, Office of Financial Management, May, 1992.

[6] Cantor, op. cit.

[7] Wei Yen, op.cit.

[8] Washington Health Services Commission, Projection of Distribution of Residents by Insurance Category. September 15, 1994, Arthur Anderson & Co.

[9] ibid.

[10] "Does Health Insurance Make a Difference?" Background Paper, Congress of the United States Office of Technology Assessment, September, 1992.

[11] OTA, op. cit.

[12] Cornelius, Beaurgard, and Cohen, "Usual sources of medical care and their characteristics" (AHCPR Pub. No. 91-042) National Medical Expenditure Survey Research Findings 11, Agency for Health Care Policy and Research, September 1991.

[13] OTA, op. cit.

[14] Healthy Options September 1995, Washington State Department of Social and Health Services, Medical Assistance Administration.

[15] John Ehmann, Washington State Health Care Authority, December 1995.

[16] Public Health Improvement Plan, November 29, 1994, Washington State Department of Health.

[17] Puget Sound Business Journal, 2/18/94

[18] Tom Hilyard and Tom Ansart, "Strategies to mitigate any possible adverse affects of insurance reforms on the individual health insurance market (Policy Analysis #96-002), Health Care Policy Board, January 24, 1996.

[19] Health Care for the Future: Showing the Way, Health Care Policy Board, 1995 Report, December 1995.

[20] OTA op.cit.